Volume 6, Issue 2

July – September 2006

Close Encounters

Your Source for Facts About Encounter Forms, Coding, Insurance Billing and Medicare Compliance Issues

Choose the Principal Diagnosis Wisely

Submitted by Cheryl Slayden, RHIT

Do you remember the movie "Indiana Jones and the Last Crusade" when Harrison Ford is about to choose the Holy Grail and was told to choose wisely? Well, that is exactly what a coder should tell themselves each time they choose a principal diagnosis, which is defined as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care" (U.S. Department of Health and Human Services, 1985, p. 31038). This principal diagnosis definition has been expanded since that time to include acute, short-term, long-term care, psychiatric hospitals, home health agencies, and nursing home and rehabilitation facilities in all non-outpatient settings.

When selecting a principal diagnosis, the coding conventions in the *International Classification of Diseases-9th Revision-Clinical Modification* (*ICD-9-CM*) take precedence over all coding guidelines. According to *Faye Browns ICD-9-CM Coding Handbook 2006 With Answers,* the coder must always review the entire medical record to determine the condition that should be designated as the principal diagnosis.

Guidelines for selection of the principal diagnosis, as described in the *ICD-9-CM* (2006, p. 16) include the following:

A. Codes for symptoms, signs and ill-defined conditions. Codes for symptoms, signs, and ill-defined conditions from Chapter 16 are not to be used as the principal diagnosis when a related definitive diagnosis has been established.

B. Two or more interrelated conditions, each potentially meeting the definition for principal diagnosis. When there are two or more interrelated conditions potentially meeting the definition of principal diagnosis, either condition may be sequenced first, unless the circumstances of the admission, the therapy provided, the Tabular List, or the Alphabetic Index indicates otherwise.

C. Two or more diagnoses that equally meet the definition for principal diagnosis. In the unusual instance when two or more diagnoses equally meet the criteria for principal diagnosis, as determined by the circumstances of admission, diagnostic workup, and/or the therapy provided, and the Alphabetic Index, Tabular List, or another coding guideline does not provide sequencing direction in such cases, any one of the diagnoses may be sequenced first.

D. Two or more comparative or contrasting conditions. In those rare instances when two or more contrasting or comparative diagnoses are documented as "either/or" they are coded as if confirmed and sequenced according to the circumstances of the admission. If no further determination can be made as to which diagnosis is principal, either diagnosis may be sequenced first.

E. A symptom followed by contrasting/comparative diagnoses. When a symptom is followed by contrasting or comparative diagnoses the symptom code is sequenced first. All the contrasting or comparative diagnoses should be coded as additional diagnoses.

F. Original treatment plan not carried out. Sequence as the principal diagnosis the condition that after study occasioned the admission to the hospital, even if treatment may not have been carried out due to unforeseen circumstances.

G. Complication of surgery and other medical care. When the admission is for treatment of a complication resulting from surgery or other medical care, the complication code is sequenced as the principal diagnosis. If the complication is classified to 996 through 999 series and the code lacks the necessary specificity in describ-

(Continued on page 2)

Special Points of Interest

VHA HIMS Monthly Satellites

Resident Supervision
October 26, 2006
11:00 am ET

AHIMA 78th National Convention and Exhibit
Denver, CO
October 7-12, 2006

First Annual VHA and DoD Meeting for Health Information Managers
Hyatt Regency Convention Center Hotel
October 12, 2006
8:00 am—4:00 pm

Inside This Issue:

(Principal Diagnosis, continued from page 1)

ing the complication, an additional code for the specific complication may be assigned.

H. Uncertain diagnosis. If the diagnosis documented at the time of discharge is qualified as "probable," "suspected," "likely," "questionable," "possible," or "still to be ruled out," code the condition as if it existed or was established. The bases for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis. **Note:** This guideline is applicable only to short-term, acute, long-term, and psychiatric hospitals.

Since the moment we were introduced to the coding world, coders have been told that documentation in the medical record is essential for choosing the most accurate principal diagnosis code selection. So, when you're uncertain of the correct code assignment of the principal diagnosis, contact the provider for further clarification. The provider will most likely be happy to assist you. If the documentation is clearly lacking critical information, ask the provider to write an addendum to the discharge summary.

Lucky for us, we don't turn to dust as the actors did in the Indiana Jones movie, when we choose the wrong principal or additional diagnosis. However, our medical center can potentially miss out on reimbursement from the Veterans Equitable Resource Allocation (VERA) classification or from monies received from the patient having billable private insurance. Choosing the wrong codes can activate a wrong clinical reminder. It can also hinder research and will be attached to the veteran for years, even after their death. This is why the coder is so valuable and such an important asset to the delivery of healthcare to our veterans. Take pride in your job and remember to "choose wisely"!

References:

U.S. Department of Health and Human Services. (1985). Uniform hospital discharge data set. *Federal Register*, July 31, 1985, *50*(147), 31038-31040.

Ingenix. (2006). *ICD-9-CM 2006 expert for hospitals*. Salt Lake City, UT: Author.

American Hospital Association. (2006). *Faye Brown's ICD-9-CM coding handbook 2006 with answers*. Chicago, IL: AHA Press.

Coding Minute: Multiple Sclerosis and VERA 2007

Submitted by Wendy Tester, CCS-P

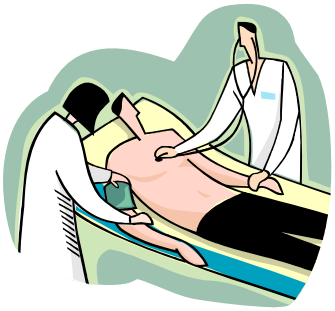
Multiple Sclerosis (MS) is a disorder of the central nervous system where areas of the brain and/or spinal cord develop areas of plaque. MS is considered a complication or co-morbidity and is reported with the *International Classification of Diseases – 9th Edition – Clinical Modification* (*ICD-9-CM*) code of 340. This condition occurs mostly in young adults and symptoms can include visual loss, dysarthria, weakness, parasthesias, and mood changes.

There are two new Veterans Equitable Resource Allocation (VERA) classes for 2007. Multiple Sclerosis is class 18, and MS with Pharmaceuticals is class 21. Both are listed in the Basic Vested class. The diagnosis codes of 340 (and 340.xx for any possible future changes to the *ICD-9-CM* codes) will be used to identify these patients when used in any 501 of the Patient Treatment File (PTF) records and can be listed as a primary or secondary code. This diagnosis will also be picked up in the outpatient setting from a primary or secondary assignment when reported on the encounter forms. The new classes may be found at the Allocation Resources Center Web site: http://vaww.arc.med.va.gov/references/references_v2.html.

References:

National Center for Health Statistics. (2006). *International classification of diseases – 9th Revision – clinical modification.* Retrieved September 22, 2006, from http://www.cdc.gov/nchs/about/otheract/icd9/abticd9.htm.

Department of Veterans Affairs. *Allocation Resources Center web site*. Retrieved September 22, 2006, from http://vaww.arc.med.va.gov/references/references_v2.html.



Understanding Resident Supervision

Submitted by Rebecca England, MHA RHIA CCP, Co-Chair, VHA HIM Coding Council

Resident supervision - these are two words that carry a lot of weight in the Department of Veterans Affairs (VA). *VHA Handbook 1400.1, Resident Supervision* places responsibility for establishing policies and processes for monitoring resident supervision with the facility Designated Education Officer (DEO) or Associate Chief Of Staff for Education (ACOS/E) at the local level. As many of us in the field have realized, monitoring and auditing of documentation requirements often falls to Health Information Management Services (HIMS) personnel and/or the Compliance and Business Integrity (CBI) program.

Resident supervision guidelines have undergone many changes during recent years due to internal VA concerns and public attention focused on the VA's program. The most recent version of the handbook dated July 27, 2005 has incorporated the VA's focus on high quality care and supervision appropriate to training requirements.

The *VHA Handbook* specifies the indicators that must be completed in order to "monitor the adequacy of supervision," whenever residents are involved. The specific areas of care to monitor include:

- Inpatient
- Outpatient
- Procedures (clinics and bedside)
- Emergency care
- Consults
- Surgeries (including 100% review of level E [Emergency surgery]/F [non-OR] OR cases).

So what role do we as HIMS, CBI and even billing professionals play in the resident supervision game? Educator? Yes! We are teachers for our provider staff; we are the ones that must read, interpret, and understand the specific requirements of the handbook in order to monitor those standards. Education of our attending and resident provider staff must occur first if our compliance with current guidelines is going to be attained. Monitor/Auditor? Yes again! Most facilities utilize the HIMS and CBI program to assist the clinical services and ACOS/E with performing these functions due to the relationship of resident supervision to documentation and billing requirements, which fall into the realm of these services.

With all the different requirements outlined in *VHA Handbook*, what are the "hot issues" on which VHA sites should focus? Here are some areas:

- Physical presence requirement: Did you know that a supervising attending physician must be physically present in:
  - All outpatient clinics involving residents
  - Emergency departments (when residents care for patients)
  - All operating room cases (minimum requirement – in the OR suite). Exceptions include:
    - Emergency Cases (as defined in 1400.1)
    - Non-OR cases, done in the OR, but truly are considered bedside/clinic procedures
    - All non-routine, non-OR procedures (in a procedure room or suite)
- Documentation requirements: *VHA Handbook* states that the medical record must clearly demonstrate the involvement of the supervising practitioner in each type of resident patient encounter.

Documentation must be entered into the medical record by the supervising practitioner or reflected within the resident progress note or other appropriate entries in the medical record (e.g. procedure reports, consultations, discharge summaries). **Pathology and radiology reports are an exception; these must be verified by a supervising practitioner.**

For most purposes, four types of attending entries and documentation are allowed:

1. Independent progress note
2. Addendum to resident note
3. Co-signature (not additional signer) of resident note
4. Reflected in resident's note (e.g. Attending of record for this patient encounter is Dr. X).

There are some situations that require an independent note/addendum by the Attending:

- Inpatient acute admission (including Intensive Care Unit [ICU]; initial note)
- Extended care admission
- Pre-Op/Procedure assessment
- Interward/Inter-service transfers (including ICU – when there is a change in attending).

So what does all this mean? Coordination, cooperation and communication are all key factors in achieving successful compliance with all aspects of resident supervision. If physical presence and documentation requirements are met, the assigned code accurately supports the bill for resident services and professional charges can then be sub-

(Continued on page 4)

(Resident Supervision, continued from page 3)

mitted to third party insurance carriers.

Since January 1, 2006, when care is provided in whole or in part by a resident and documentation shows the resident was supervised in accordance with VA policy, coding staff are to assign modifier "GR" to each CPT code in order to denote care provided by a resident under the direction of a teaching physician.

Many reference and educational tools have been developed for resident supervision. Links to these tools can be found on the Office of Academic Affiliations Web site at this URL: http://vaww.va.gov/oaa/resources_resident_supervision.asp, those listed include:

- Resident Supervision Pocket Card
- *Resident Supervision in Teaching Hospitals* (Chang, 2005)
- *Resident Supervision On-Line Training Course* (http://vaww1.va.gov/memphis/ontap/128/index.cfm)
- SOARS Reviews (Department of Resident Affairs, 2004)
- FAQ's.

Should you have questions regarding the resident supervision program, contact the DEO or ACOS/E at your facility for additional information. You can also submit questions regarding billing for resident care to the Reasonable Charges Policy Group at http://vaww1.va.gov/cbo/rcbilling.asp or by reviewing *VHA Directive 2005-054: Revised Billing Guidance for Services Provided by Supervising Practitioners and Residents* (VA/VHA, 2005).

References:

Chang, B.K. (2005). Resident supervision in teaching hospitals. *ACGME Bulletin*, September 2005, 12-13.

Department of Veterans Affairs, Veterans Health Administration. (2005). *VHA Handbook, 1400.1, Resident supervision.* July 27, 2005. Washington, DC: Author.

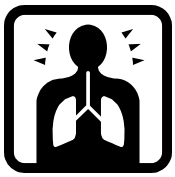
Department of Veterans Affairs, Veterans Health Administration. (2005). *VHA Directive 2005-054: Revised billing guidance for services provided by supervising practitioners and residents.* Washington, DC: Author.

Department of Veterans Affairs, Veterans Health Administration. (2004). SOARS conference call: Resident Supervision Presentation, December 7, 2004.

Department of Veterans Affairs, Veterans Health Administration. (2006). *Office of Academic Affiliations: Resident supervision resources*. Retrieved September 22, 2006, from http://vaww.va.gov/oaa/resources_resident_supervision.asp.

Pneumonia is Still a 'P'number One Problem

Submitted by Denise Hamilton, RHIA CCS-P



Coding pneumonia has been a coding nightmare for many years and still remains on hospital Diagnosis Related Groups (DRG) risk lists. The dilemma arises between the way physicians document pneumonia and the way coders are instructed to code pneumonia. Coders must follow *International Classification of Diseases-9th Revision-Clinical Modification* (*ICD-9-CM*) coding guidelines and guidance published by *Coding Clinic*, the publication of the *ICD-9-CM* Central Office.

There are four DRGs for pneumonia which apply to the VA population: 1) 79 (Respiratory infections and inflammations age >17 with complication/co-morbidity, pneumonias due to pseudomonas, staphylococcus, gram-negative organisms and aspiration of food or vomitus); 2) 80 (Respiratory infections and inflammations, age >17, without complication/co-morbidity); 3) 89 (Simple pneumonia and pleurisy, age > 17, simple pneumonia and pleurisy, age >17 with complications/co-morbidites, unspecified organism); and 4) 90 (Simple pneumonia and pleurisy, age > 17 without complications/co-morbidities). The appropriately selected DRG depends on how the pneumonia is documented and thus coded.

Incorrect coding still persists and the reasons for incorrect coding are still the same: lack of physician documentation to support the rules that coders must use to correctly code the condition. Coders by their nature are very detail-oriented and they are always striving to gather as much information to select the correct code. The dilemma arises when the clinical data (chest x-ray, sputum cultures, laboratory results, signs and symptoms) are present and qualify for pneumonia, but the physician does not specifically state pneumonia or type of pneumonia. Coders need to caution themselves and not code based on the presented clinical data. Coders cannot use laboratory or radiology reports to code. They can only gather the data from the actual physician documentation. Doing so can cause more problems than not coding pneumonia. Coders must "wait" until the clinician puts it all together. Formulating the clinical data for an accurate diagnosis must remain the responsibility of the clinical staff. What is a coder to do if there is inadequate documentation?

One answer is to query the clinician. Yes, this takes time and a bit of effort but if additional information can be obtained, then it is worth the extra time. Just remember to have the clinician document the requested information. The second tactic (and hopefully more profitable in the long run) is education. Clinicians need to be educated about the necessary information required for proper pneumonia coding. Was it acute or chronic? What were the sputum culture results? What was the organism responsible for the infection? Was aspiration involved? What was aspirated? Was respiratory failure involved; was it acute or chronic? Why was the patient admitted (respiratory failure or pneumonia)? Was the patient intubated or put on a ventilator? Are there other complications/co-morbid conditions that may have contributed to the increased length of stay? These are all questions that can be posed to the clinician to obtain better documentation.

In summary, remember some simple rules:

1) Code from information presented by the clinician, not from radiology or laboratory reports.

2) Do not use the symptoms to assist in coding

(Continued on page 5)

(Pneumonia, Continued from page 4)

pneumonia.
3) Conditions integral to pneumonia are not to be coded.
4) For inpatient episodes of care, diagnoses stated as "possible, probable, suspected or rule out" can be coded as confirmed diagnoses.
5) Code only the organism that was documented by the clinician; not what was found on a laboratory report.
6) Lobar pneumonia is not the same as pneumonia in a lobe of the lung.
7) Query the clinician if the diagnosis is unclear.

These items may seem like obvious pieces of documentation, but physicians are under a lot of pressure to treat the patient as quickly and efficiently as possible, and time constraints may cause documentation to be insufficient for the coder to select the correct code. Education of clinical staff is the key to proper coding.

If we work as a team and educate our clinical staff we can assure proper coding and reimbursement and avoid any potential difficulties with the Office of the Inspector General due to improper coding.

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Atlantic Information Services. (2006). Despite years of audits and enforcement, DRG 79 errors still plague some hospitals. *Report on Medicare Compliance, 15* (27), 1, 6-7.

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Coding Impacted Cerumen of the Ear

Submitted by Sandy Bailey

Sometimes ear wax accumulates in the ear causing an obstruction which can cause hearing loss. This can be caused by using Q-tips, hair pins, or other objects put in the ear, previous surgery, or other factors. When coding impacted cerumen of the ear use the diagnostic *International Classification of Diseases-9th Revision-Clinical Modification (ICD-9-CM)* code 380.4 and the *Current Procedural Terminology* code 69210. Irrigation is the most common method of removing ear wax. This is done by washing out the ear canal with water.

Hospitals reporting earwax removal by a physician on the same day as audiologic function testing (codes 92553 through 92598, except for noncovered codes 92559 and 92560) should use the new Healthcare Common Procedure Coding System (HCPCS) Level II code G0268: *Removal of impacted cerumen (one or both ears) by physician on same date of service as audiologic function testing.*

Coding tip: The Centers for Medicare & Medicaid Services (CMS) will deny payment for earwax removal if the standard CPT code for removal of ear wax is reported.

Getting to Know Your Coding Council

Cheryl Slayden has worked in the Health Information Program for the Department of Veterans Affairs for over twenty years. She has applied her diversified coding and billing skills to this work experience for eighteen of these years. This experience includes inpatient, ambulatory surgery, Evaluation & Management, physician professional fees, anesthesiology, pathology and laboratory coding, and billing.

During her professional career, Ms. Slayden has assumed a variety of roles in the healthcare continuum, including health information analyst, health information technician and health information administrator. Her ability to create and manage project teams to achieve objectives within budget parameters makes her a respected healthcare consultant in the field today. Currently, she is the Supervisor of health information management at the John Cochran and Jefferson Barrack Divisions of the VA Medical Centers in St. Louis, Missouri. She is a charter member of the VHA Health Information Management Coding Council and active member of professional organizations, including the American Health Information Management Association (AHIMA).

Denise Hamilton, RHIA, CCS-P, has been with the VA since March of 1983 and with the same medical center, the Richard L. Roudebush VAMC in Indianapolis, IN. Her primary responsibility has centered on coding but has also included audits, assessing HIMS processes, projects related to release of information, file room and records processing, and most recently, working with laboratory preparing for the upcoming Clinical Indicators Data Capture patch. She has been on the council since inception and enjoys the challenges and opportunities it provides.

Emergency Room Visits

Submitted by Wendy Tester, CCS-P

Trips to the emergency room (ER) can be tricky to code, especially if you have an urgent care (UC) area in the same facility or literally in the same area. There are several points to remember when selecting the correct Evaluation & Management (E/M) code, and even more documentation tips for physicians and providers to remember when documenting these services.

When coding, the first item to identify is the code category (ER 99281-99285 or UC 99201-99215). An ER is located in an organized hospital based facility, is open 24 hours a day and provides care to patients who present for immediate attention to their life-threatening injury or illness. Most patients present for this type of care for conditions that pose an immediate threat to their life or bodily function.

It is important to remember to consider the presenting problem and not just the final diagnosis when determining the category to select. The patient will present based on the signs and symptoms they are experiencing and would not necessarily know the severity of the condition causing the problems. As a result, the patient may present for chest pain but ultimately be found to have reflux disease. Typically, reflux is not a life threatening problem and in itself may not support the ER code, but the reason the patient presented to the ER (chest pain) will support that category. In many facilities, there is a triage service provided by the nursing staff who will determine the medical severity of the patient's condition and coders would use the nursing disposition documented in the medical record to also support which category to select. If the ER triage staff member determines the patient's condition does not meet the criteria for an "emergency," the coder would select a code from the new or established office or other outpatient categories for the care provided in the UC setting.

When reporting ER codes, the documentation must meet or exceed all three components of that level to justify reporting that level. As the patients are presenting for immediate attention to the illness or injury, the physician is required by law to perform some screening exam components regardless of what signs or symptoms the patient presents. As such, there is only one category of codes to choose from and there is no difference between a new or established patient. Moreover, as the patient presents to the ER for the unscheduled immediate attention to an illness or injury, counseling or coordination of care is not applicable in these cases and time is not an option to select the correct code level.

When reviewing the history, you may find more cases where the physician is unable to obtain a complete history due to the patient's presenting condition. It is important that physicians document the reason they are unable to obtain the history they need to treat the patient for both medical as well as for coding purposes. When the physician has documented in the medical record the reason they are unable to obtain further information or a complete history due to the patient's presenting problem, s/he is able to take credit for a complete history which may influence the overall level of the code you select. If the physician is obtaining the history from someone other than the patient, documentation of that fact may support a higher level of medical decision making as it is more difficult to treat a patient when information is provided by a third party, especially when the physician cannot confirm the information with the patient.

When determining the medical decision making level, consider and count (if applicable) the number of presenting problems when identifying the number of diagnoses/treatment options and do not rely solely on the final diagnosis. Do not count and separately code related conditions. For example, it a patient has fallen and has a swollen and sprained wrist, don't count the wrist sprain and swelling as separate issues, as swelling would normally occur with a sprain.

As patients don't present for continuing care in an emergency room, remember to identify the problems as a new problem, with or without additional work-up. Medical decision making should be viewed as what the patient presented with and what was done to treat the condition(s). When finding the overall level of risk to the patient, the management options will most frequently support the higher level of medical decision making. Many of the patients are given medications by mouth, by injection or through infusions. When the physician has documented a review of the medication list or of the nursing notes that contain the patient's current medications, this documentation supports a minimum of a moderate level of risk.

When documenting and coding ER services, if there are questions as to what needs to be documented or how to interpret anything the physician has documented, communication between the physicians and coders is key to confirming adequate and accurate documentation. Physicians and coders are always encouraged to seek out each other to provide the most accurate representation of the services provided to the patient.

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Decision Health. (2006). *Coding answer book 2006* (pages 15001-15014, 15518-15519). Salt Lake City, UT: Author.

American Medical Association. (2006). *Current procedural terminology 2006*. Chicago, IL: AHA Press.

Questions and comments about *Close Encounters* may be sent to Rebecca.England@va.gov